starbloom PAEDIATRICS

Who We Are

Starbloom Paediatrics is one of the newest paediatric practices in Perth and we aim to lower the barrier of entry into private paediatric practice. Before opening, we spent a lot of time consulting with paediatricians who had negative experiences in private practice to try and overcome as many of these issues as possible.

We now have a diverse range of paediatricians and encourage a collaborative environment of children's health specialists. While we do have developmental paediatricians as associates, this submission should be taken as representative of the views of the Directors of Starbloom only. While our Medical Director & CEO Dr Robert Lethbridge continues to work as a paediatric Respiratory & Sleep consultant at Perth Children's Hospital, this will contain no information obtained through his work there beyond speaking in broad generalities about processes, all knowledge of which can be obtained publicly.

We apologise for not placing this submission earlier and appreciate the extension to the deadline that has been granted to us.

Current Situation

As we are sure has been made evident in other submissions, the demand for the services of the Child Development Service (CDS) is enormous and puts it under significant strain. At Starbloom, referrals for Attention-Deficit/Hyperactivity Disorder (ADHD) and Autism started to arrive even before we were officially open to referrals, based on rumour and word-of-mouth. We remained open to referrals for less than one week for this specialty due to the overwhelming demand, and we are aware of a colleague who received more than 400 developmental referrals in two weeks.

Even as we slowly increase the number of specialist developmental paediatricians working with us as associates, we will not be re-opening developmental referrals due to the backlog that exists from that very brief opening period. Despite clearly documenting on our website and in any advertising that we have no capacity for further referrals, questions about the availability of developmental assessments are still amongst the most common enquiries that we receive.

The reason for this backlog is obviously complex and multi-faceted. Developmental concerns are common, but diagnosis is rarely simple. Untangling the frequent existence of other co-morbid conditions and the potential for other diagnoses that may better explain the

symptomatology is both time-consuming and complex, requiring a high level of expertise. Both diagnosis and ongoing management can be stressful experiences for both patient and clinician, with a high level of documentation and communication not just between medical specialists but other allied health professionals, schools, and many others taking up much more time outside of face-to-face assessments than is typical of other paediatric specialties.

For a variety of reasons, the number of clinicians in this space has not increased in line with the demand, and training pathways are long and beyond of the control of government. The Royal Australasian College of Physicians – quite rightly – insists that there be a level of supervision that makes increasing the number of trainees difficult without significantly increasing the staffing of the Child Development Service which, due to the above issues, is already struggling to maintain their own levels of staffing. The service provided by the CDS is phenomenal, and the staff are incredibly diligent and hard-working; however, they are only able to achieve so much with the time and resources that they have.

Ways Forward

The Child and Adolescent Health Service Board recently released their Strategic Plan for 2023-2025, and amongst their 8 strategic priority areas is the building of External Partnerships. While we are unable to speak to improvements *within* the CDS with any authority, I feel that the building of these partnerships is an area in which Starbloom can provide insight. Some potential avenues to help in this area are detailed below.

Workforce Survey

Assessing why the numbers of developmental paediatricians has not kept pace with the demand by surveying both those who remain in the profession as well as those who have left would allow improvements in recruiting people into this space. By exploring the barriers, progress could be made to encourage more people to enter this field of paediatrics and help train more clinicians.

Shared Private / Public Clinical Spaces

While staffing is the major limiting factor for diagnosis and assessment, finding the physical space in which to conduct assessments and review patients is already challenging and will become increasingly difficult if CDS staffing numbers increase.

Partnerships with private paediatric practices to rent space to the CDS would allow more flexibility and would utilise the flexibility that exists in private practice to expand premises and acquire new space more swiftly than under the stewardship of a government agency. This could potentially allow the creation of new ‘micro-clinics’ distributed throughout the community, moving care closer the patients.

Creation of Grants to Expand Private Services

The creation of a grant process explicitly to either expand private assessment space or to create a new public/private partnership would have both immediate and long-term benefits. Access to grants would allow the creation of new developmental paediatric centres, and expansion of existing ones. The costs of setting up a private practice are significant, and any support that can be provided to lower the barrier to entry could result in an increase of physicians in this space.

Beyond providing more space for the CDS to perform its work for minimal outlay, it would also lower the psychological barriers of entry for clinicians who are currently not keen to enter the private workforce. Explicit support from the government/CDS to build such partnerships would potentially increase the number of physicians willing to work privately and increase the number of patients they can provide care for.

Direct Public 'Triage' to Private Referral Pathway

One disadvantage of private practice is that it is often a less collegiate experience than the CDS; private practice can feel more isolated than having the support of the diverse services that the CDS is built to provide. While this is an area Starbloom and others are working on, currently many specialists in private practice are solo practitioners. While this is usually adequate, there are some patients who have a level of complex needs that is better suited to the structure of CDS, whereas others may not require such a high level of support.

Allowing the CDS to triage and refer patients that are not felt to have complex needs to private practice would allow the CDS to focus on the areas they excel at, while private clinics share the workload and are able to review more patients. Current efforts at triaging like this in a per-practice way are inefficient and require staffing levels that are not sustainable.

CDS triaging may also have an added benefit; by effectively creating a 'central register' for developmental assessments which can then be passed on to private providers, it would give greater clarity around levels of need, more equitable service provision, and limit the doubling-up (or more) of referrals to numerous separate private services for parents desperate to find any openings.

Expanded GP Co-Prescribing

Currently, General Practitioners are allowed to continue to prescribe the same dosage of dexamphetamine for patients with ADHD on an ongoing basis, but any change in medication dose requires a visit to a developmental physician. Expanding the co-prescribing ability to potentially allow a defined 'range' of medication dosage, accompanied by explicit instructions about when to consider such changes and the side-effects to monitor for, would reduce the frequency of visits. This would empower GPs and allow developmental physicians to see more new patients.

Improved Systems & Pathways

There are no doubt inefficiencies in diagnostic and treatment pathways that would benefit from improvement. Working to improve this can only effectively be done by clinicians with experience in the service, and while this is traditionally the job of a Head of Department, the clinical workload is such that this becomes impractical. Cordoning off explicit and protected time for developmental clinicians to work exclusively on service redesign, innovation and improvement would provide long-term dividends but requires investment and sufficient support to ensure that this time does not get lost to clinical work.

Electronic records and other system-wide improvements are likely beyond the scope of this inquiry but would provide definitive efficiency dividends and allow patient throughput and communication to improve.

Areas of Caution

Broadening Diagnostic Pathways

We would advise against any significant change to the requirements for who can make a diagnostic assessment of Autism or ADHD. These assessments are complex, time consuming, and require a high degree of specialist knowledge. Any expansion to who is allowed to make these diagnoses should be treated with caution to maintain accurate diagnosis.

Publicly Funding Private Assessments

While superficially attractive, there is currently little to no capacity in private practice, and this would do nothing to increase staffing or availability of appointments if done on its own.

Summary

Developmental paediatrics is an increasingly in-demand specialty with highly complex patients and limited throughput of new specialists. While it is unlikely that there are any quick or easy fixes in this area, there are opportunities to build a partnership between the centralised – and excellent - Child Development Service and private practices in the community. There are strengths and weaknesses to both models, however by exploring and utilising potential synergies, there are exciting opportunities to improve the provision of care and provide a world-class service for the children of Western Australia.

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